

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 700 Primary Registration District No. 5726 Registrar's No. 125 **63-032881**

1. PLACE OF DEATH a. COUNTY <u>Macon</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Macon</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Middle Fork</u>		c. CITY OR TOWN <u>Jacksonville</u>	
Length of stay in 1b <u>5 years</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2mi. N.E. of Jacksonville</u>		d. STREET ADDRESS (If outside, give location) <u>2mi. N.E. of Jacksonville</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Stanley</u> Middle <u>None</u> Last <u>Delaney</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>29</u> Year <u>1963</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>12-27-1889</u>
9. AGE (last birthday) <u>73</u>		10. IF UNDER 1 YEAR Months <u>--</u> Days <u>--</u> Hours <u>--</u> Min. <u>--</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grain & Livestock</u>	
11. BIRTHPLACE (City and state or country) <u>Monroe County, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James F. Delaney</u>		13b. MOTHER'S MAIDEN NAME <u>Viria Snidow</u>	
14. NAME OF HUSBAND OR WIFE <u>Ruth Delaney</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO. <u>3-A</u>		17. INFORMANT <u>Mrs. Stanley Delaney</u>	
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH <u>Shocking</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from _____ to <u>Aug 29, 1963</u> and last saw her alive on <u>None</u> Death occurred at <u>8:30 a.m.</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>James E. Campbell MD</u>		22b. ADDRESS <u>Macon Mo</u>	
22c. DATE SIGNED <u>8/30/63</u>		(State)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>8-31-1963</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Hill Cemetery</u>		23d. LOCATION (City, town, or county) <u>Madison, Mo.</u>	
24. FUNERAL DIRECTOR <u>Thompson-Mackler</u>		ADDRESS <u>Madison, Mo.</u>	
25. DATE RECD. BY LOCAL REG. <u>9-2-63</u>		26. REGISTRAR'S SIGNATURE <u>Ruth M. Neely</u>	

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

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Rev. 4/59

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SEP 12 1968

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Joseph R. MacJelen

Licensed Embalmer No. 4571

P. O. Address

Madison, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.